STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	153515	A. BUILDING _____ B. WING _____	R-C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH ADULT DIALYSIS CENTER	2140 N CAPITOL ST INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{V 000}	INITIAL COMMENTS This visit was a follow-up to the ESRD federal complaint survey that was conducted on 9/18-25/13. Complaint #s IN00136608 and IN00136200 - Substantiated: Federal deficiencies related to the allegation were cited. Unrelated deficiencies were also cited. Survey date: November 4, 2013 Facility: 003229 Medicaid Vendor: 200383830 Surveyor: Susan E. Sparks, RN, PHNS Four Conditions for Coverage and 27 standard level deficiencies were corrected with this survey. Indiana University Health Adult Dialysis Center is in compliance with the Conditions for Coverage 42 CFR 494.30: Infection Control, 494.60 Physical Environment, 494.110 Quality Assessment and Performance Improvement, and 494.150: Responsibilities of the Medical Director during this survey. Quality Review: Joyce Elder, MSN, BSN, RN November 5, 2013	{V 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE